AN ADMINISTRATIVE REVIEW OF THE ORGANIZATION AND STAFFING POLICIES OF THE DEPARTMENT OF HEALTH

MARCH 1975

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

MEMBERS

Assembly	Senate
Bob Wilson, Chairman	Anthony C. Beilenson
Eugene Chappie	Clare L. Berryhill
Mike Cullen	George Deukmejian
John Francis Foran	James R. Mills

Joint Legislative Audit Committee

GOVERNMENT CODE: SECTIONS 10500–10504

California Legislature

BOB WILSON
CHAIRMAN
ROOM 4126, STATE CAPITOL
SACRAMENTO, CALIFORNIA 95814
(916) 445-6161

March 19, 1975

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of
the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members:

I am today releasing the report of the Auditor General on the reorganized Department of Health, originally requested by Assemblyman Mike Cullen.

The department's current budget is $3 billion annually, of which half is state money. The department employs 21,000 persons and administers Medi-Cal, community mental health programs, social service programs for welfare recipients, and programs for the developmentally disabled.

The reorganized department became effective July 1, 1973, merging the responsibilities of the former Departments of Mental Hygiene, Health Care Services and Public Health, along with assuming responsibilities for certain functions of the Departments of Social Welfare and Rehabilitation.

The purpose of the reorganization was to promote consolidation of fragmented programs, provide a more efficient and accountable organization, and reduce staffing by 600 positions.

However, the staff of the Auditor General has concluded reorganization has not met stated goals:

- More time, money and effort is required to do the same work

- Federal financial participation could be in jeopardy

- Accountability has not increased with 46 percent of the 93 top administrators changing job assignments five or more times since July 1970

- Projected staff reductions, estimated at 600, cannot be verified.

The Auditor General's staff assesses the chief reasons for the shortcomings as follows:

- Organization along functional rather than program lines has not been successful

- Relationships between state and local governments responsible for delivering health and welfare services have deteriorated

- Rotation of personnel has weakened performance.

Chief recommendations growing out of this study by the Office of the Auditor General include:

- Future Department of Health changes should consolidate program efforts, not functions

- More effort should be expended to guarantee state eligibility for federal funds

- Staff rotations should be reduced.

The Acting Director of the Department of Health has withheld comment on the report pending a review, but he and his staff have expressed their appreciation and generally concurred with the findings and recommendations.

Respectfully submitted,

Bob Wilson

BOB WILSON, Chairman
Jt. Legislative Audit Committee

STATE OF CALIFORNIA

Office of the
Auditor General

925 L STREET, SUITE 750
SACRAMENTO, CALIFORNIA 95814
(916) 445-0253

HARVEY M. ROSE, C.P.A.
AUDITOR GENERAL

GLEN H. (JACK) MERRITT, C.P.A.
CHIEF DEPUTY AUDITOR GENERAL

JERRY L. BASSETT
ATTORNEY-AT-LAW
DEPUTY-CHIEF COUNSEL

PHILLIPS BAKER, C.P.A.
GERALD A. HAWES
JOHN H. McCONNELL, C.P.A.
DEPUTIES

March 12, 1975

Honorable Bob Wilson
Chairman, and Members of the
Joint Legislative Audit Committee
Room 4126, State Capitol
Sacramento, California 95814

Dear Mr. Chairman and Members:

Transmitted herewith is our report on the reorganization and staffing policies of the Department of Health. The report also includes our assessment of the impact of the department's organizational structure on the administration of local health and welfare programs in the state.

Respectfully submitted,

Harvey M. Rose
Auditor General

Staff: Jerry L. Bassett
Gerald A. Hawes
Virgil W. Woods
Carla M. Duscha

TABLE OF CONTENTS

INTRODUCTION

In response to a legislative request, we have conducted an ongoing review of the Department of Health. This report is an administrative review of the internal organization and staffing policies of the reorganized 20 month old Department of Health and assesses the effect of that department's organizational structure on the administration of local health and welfare programs throughout the state.

The idea of a consolidated Department of Health dates from at least 1967, when a Legislative Analyst study entitled, A Report of the Availability and Cost of Health and Medical Care in California was issued. This study pointed up the need to establish a more efficient organizational vehicle to deliver the state's health services. The Assembly Public Health Committee discussed the concept in a 1968 report. Momentum began to build when the Human Relations Agency secretaries requested task force reports in 1968, 1969 and 1970.

Governor Reagan's Reorganization Plan No. 1, of 1970, proposed consolidation of these functions into the department. The plan became operational under applicable provisions of law. Legislation making the statutory changes necessary to implement the reorganization was passed the following year (Ch. 1593, Stats. of 1971).

The Legislature ordered two one-year delays, setting back the implementation of the plan until 1973. During this period, a reorganization committee, made up of directors of the three departments to be consolidated, plus the secretary of the Human Relations Agency, directed the planning efforts for the new department. The committee's efforts were supported by two task forces made up of the chief deputy directors and designated staff of the three departments. Rand Corporation, which was hired to act in a consultant capacity, provided conceptual advice to the committee. Final plans were submitted to the Legislature in early 1973. Despite expressed reservations by a number of legislators, the plan was approved and implementation began April 1, 1973. Actual reorganization was effected on July 1, 1973.

The reorganization resulted in the consolidation of the responsibilities and jurisdiction of the former Departments of Mental Hygiene, Health Care Services and Public Health. In addition, the social services function of the former State Department of Social Welfare and the disability determination function of the Department of Rehabilitation were assumed by the Department of Health.

The new Department of Health was to consist of five health systems: (1) health administrative systems; (2) health quality review systems; (3) health financing systems; (4) health protection systems; and (5) health treatment systems.

Each of the five health systems is administered by a deputy director classified in the Career Executive Assignment (CEA) class. On July 1, 1974, a sixth CEA deputy director was appointed to head the newly created office of health planning and intergovernmental relations.

The total estimated budget including matching funds from the federal government and county and local governments as well as state appropriated funds for the Department of Health in the 1974-75 fiscal year is approximately $3 billion. The state share of this total is approximately $1.5 billion.

Included in this amount are:

- $2 billion for the Medi-Cal program, which is a joint federal-state program providing health care to those eligible persons who cannot pay the full cost of medical care

- $268 million for financial support of the state's 60 county and community mental health programs as provided for by the Short-Doyle Act and for maintenance of state hospitals for the mentally disabled

- $339 million for social services to individuals who are currently, potentially or formerly welfare recipients

- $224 million for developmentally disabled individuals with lifetime problems. Such individuals require treatment and maintenance care through the state's regional centers, state hospitals exclusively for the mentally retarded and developmentally disabled, and Community Services Section.

These programs account for 92 percent of the department's budget.

The development of an efficient organizational structure to supervise the administration of a multibillion dollar service delivery system employing 21,000 persons presents highly complex problems. Furthermore, any organization that must provide services and set priorities for services to such disparate groups

and interests as are represented in the constituencies of the Department of Health cannot escape criticism nor avoid friction.

Early in our review, however, it became apparent that 15 months after the reorganization had been completed there was still a great deal of expressed concern about the administration of the Department of Health and the effectiveness of its program operations. These concerns ranged from the lack of outside input in the initial planning of the organizational structure to the continuing difficulty in finding personnel who are responsible for specific program areas. Complaints have come from legislators, county administative officers and other affected parties.

Our review efforts were therefore two-phased: Phase one consisted of an internal review of the history and organizational structure of the department, on-site interviews with department officials, review of personnel practices, files and transactions. Phase two consisted of a questionnaire survey. We surveyed the directors of five county-administered health and welfare programs in each of the state's 20 largest counties. (These 20 counties account for approximately 89 percent, or 18,050,200, of the state's population of 20,265,000.) We sought opinions of county administrators in the evaluation of the Department of Health because over 85 percent of the department's budget is allocated to programs administered by county governments under state supervision. We made no effort to substantiate by independent audit activity any allegation made by any of the county administrators who responded to our questionnaire. The purpose of the questionnaire was to explore how the Department of Health was perceived by those persons responsible for the day-to-day administration of programs funded by the Department of Health.

It is the directors of these county programs who are among the people who have the most frequent, consistent and important dealings with the department.

Before the questionnaire was mailed out on September 27, 1974, it was reviewed by Department of Health officials and their suggestions were accepted and incorporated into it. The last question (number 14 in the appendix) was specifically included at the request of the Department of Health. Our questionnaire was specifically designed to elicit assessments on how well the Department of Health is fulfilling its responsibilities to local governments in the areas of issuing regulations, monitoring compliance with regulations, and providing consultation, and whether the department's staffing policies helped or hindered its ability to do its job. There were 14 questions for the respondent to answer. Three questions were open-ended and asked for general comments. The other 11 questions were structured to provide a limited number of responses, i.e., yes, no or not applicable. A summary of these 11 responses is included as an appendix to this report. Specific responses are also included in the body of the report where it was deemed appropriate.

FINDINGS

THE CURRENT ORGANIZATION OF THE DEPARTMENT OF HEALTH ALONG FUNCTIONAL LINES RATHER THAN PROGRAM LINES HAS NOT ACHIEVED ITS STATED GOALS OF PROMOTING THE CONSOLIDATION OF FRAGMENTED PROGRAMS, OR OF PROVIDING AN ORGANIZATION CAPABLE OF ASSUMING LEADERSHIP AND FIXING RESPONSIBILITY.

When the Department of Health was created, it was organized according to functional responsibilities and not according to separate programs. A function is one of many activities necessary to administer an overall program. For example, the licensing functions in social services, mental health and public health were combined into one licensing unit. While it was designed to eliminate duplication within the department, it also had the effect of breaking up responsibility for the social and health programs. While it was designed for internal efficiency, it was required to operate within a framework where the other units of government in that framework were organized quite differently. Appropriated funds from both state and federal governments continue to be made available for the purpose of supporting specific program efforts and achieving specific program results. The organization of county governments charged with the actual expenditure of these funds reflect a program rather than function orientation.

In proposing the Department of Health, the administration set forth the following statement:

> "Establishment of the Department of Health is not a panacea for all the state's problems related to health. It will, however, improve substantially our ability to service these problems. It will permit us to do a more effective job of evaluating total health needs and developing programs to meet them. It will stimulate

> the setting of goals and priorities and the rational allocation of resources. It will provide an organization capable of assuming leadership in such areas as health manpower and comprehensive health planning. It will permit the consolidation or coordination of programs that are now fragmented. It will enable us to fix responsibility and accountability for program results. It will foster the coordination of health and social services at both the state and local level with a consequent improvement in service to the public, and it will provide an atmosphere that encourages innovation in such fields as the health care delivery system..." (Emphasis added)

Our review of the effects of the July 1, 1973 reorganization of the Department of Health has identified major problems in the areas of social services, Medi-Ca health services and other health services which, in our judgment, are attributable at least in part to the reorganization of the Department of Health along functional lines. Environmental health, which assumed most of its functions intact from its predecessor agency, the Department of Public Health, does not reflect similar adverse effects of program fragmentation. Finally, we were not able to find any evidence that consolidation of functions at the state level produced economies of administration at the local level.

1. Social Services

The federal appropriation for social services for California, fiscal year 1974-75, is $245,500,000. The federal government requires that this amount be matched with a 25 percent contribution of state and county funds. The total amount is then available for the purchase of specified types of services. Some services such as protective services for children and adults, family planning, etc., are mandated by the federal government while the provision of other services such as community planning, day care services to adults are left to the options

of individual states (45 CFR, Secs. 220 and 222). The federal government requires as a condition to the receipt of federal funds that such services as are provided be made available on a statewide basis (45 CFR, Sec. 205.120).

The July 1973 reorganization separated program responsibility from fiscal accountability. The new Department of Health (DOH) acquired program responsibility from the State Department of Social Welfare (SDSW), which became the Department of Benefit Payments (DBP) and which acquired the responsibility of auditing and fiscal control.

The Department of Health now has the responsibility for establishing priorities among county welfare departments to insure that mandated services are provided. Such priorities have not been established. Neither the Department of Health nor the Department of Benefit Payments has conducted a systematic review of county programs since the reorganization of the Department of Health in July 1973.

The provision of services on a statewide basis as well as the provision of mandatory services is a condition of continued federal participation in the social services program.

Our review of ten county welfare departments conducted in the fall of 1974 disclosed wide variations in each county which appear to be in violation of federal requirements. This condition could jeopardize the continuation of federal funding.

Program Fragmentation in Foster Care Program

In July 1974, we issued a report on the fragmentation of foster care programs in the Department of Health. At that time, we wrote:

> "The organizational structure of foster care programs in California illustrates that there is no single organizational unit within the State Health and Welfare Agency responsible for coordinating the activities or formulating policies and standards for all of the children who must live out of their own homes. In fact, as shown on the organizational chart, there are 14 separate Health and Welfare Agency organizational units charged with the administration of foster care programs."

The development of the foster care organizational chart, which was shown in our July 1974 report, required several hours of interviewing on our part because we were not able to locate any one person in the Department of Health who had certain knowledge as to the placement of each of the various component units that carried some responsibility for these programs.

Comments From County Welfare Directors Regarding the Effects of Reorganization of Social Services.

With few exceptions, county welfare directors who responded to our questionnaire were critical of the Department of Health. This group's collective assessment of consolidation is best expressed in the following comments: (Consolidation) "...downgraded social services (most unfortunate), deprofessionalized staff and increased employee rotation". Another director said his agency had been forced to operate without state program regulations because of general inadequacies in the state's social services unit.

> "This absence of state direction forced our agency to try to guess what should be appropriate operating procedures -- guesses which later had to be corrected when the state units finally released the regulations."

Among the programs most cited by welfare directors for failure to release guidelines and policies, was the homemaker/chore program, which underwent significant changes during this period. Among the offices most cited as inefficient and giving poor service was the licensing unit.

II. Medi-Cal Health Services

The Medi-Cal program, which is the largest program operated by the Department of Health, offers a prime example of program fragmentation. Medi-Cal serves about 2.5 million needy individuals and costs the state approximately $1 billion in 1973-74.

Again, the July 1973 reorganization separated program responsibility from fiscal accountability. The Department of Benefit Payments (DBP) acquired the responsibility of auditing, collecting overpayments and conducting administrative hearings.

There has been a lack of communication and coordination between the two departments and within the Department of Health itself, which is causing program inefficiencies not only at the state level, but at the local level as well.

The Department of Finance audit, issued on December 30, 1974, reported the following case involving the issuance of conflicting instructions in the Medi-Cal program:

> "...agency jurisdictional conflicts were reported by one county in our sample. The first dealt with instructions that were received from DOH and DBP which were contradictory. This is an example of the lack of coordination between DOH and DBP. The effect on administrative costs is observable in county duplication of work and effort and was not restricted to the county where it was observed since the instructions were issued statewide..." (Emphasis added)

Duplication of Functions of Medical-Social Review Teams and Licensing Unit

The Code of Federal Regulations (45 CFR 250.23) requires states participating in the Medicaid program to review patient care to assure the best use of Medicaid funds.

Section 13911 of the California Welfare and Institutions Code provides for such a review of Medi-Cal patients:

> "The plan established by the Director of Health pursuant to this section, may include the use of an interdisciplinary review process to insure that persons are not placed or retained in medical care facilities when appropriate care can otherwise be provided at lower cost."

The Department of Health has implemented this provision through its Medical-Social Review (MSR) program. Sixteen MSR teams are currently located throughout the state. Each team's staff of usually one physician, a nurse and a social worker is responsible for reviewing the initial and subsequent authorization requests for Medi-Cal patient care in licensed nursing homes and intermediate care facilities.

Section 50028.1 of Title 22 of the California Administrative Code lists a second purpose of the MSR program: "...to determine the quality and adequacy of the services being provided each beneficiary".

This second MSR function, the first concerns individual placements, duplicates the function of the Department of Health's licensing and certification section, which is responsible for maintaining state standards for all medical facilities. The licensing and certification section maintains review teams in each of the six districts covering the state. Each team includes usually four registered nurses and four generalists who are experienced in some technical or administrative aspect of institutional medical care. A review of each long-term care facility is required twice annually without providing advance notice of each inspection.

The MSR teams which have been administratively placed in the field services section of Health Financing Systems, do not have the authority to order changes or issue sanctions when they find a facility out of compliance with licensing regulations. Authority to enforce licensing regulations resides exclusively with the licensing unit which has been administratively placed in the facility licensing section of Quality Review Systems. The channel for communications between these two units goes through five administrative layers.

Our review of the MSR teams had disclosed that there are no structured or mandated methods by which findings or facility noncompliance are transmitted to the licensing unit. The federal Department of Health, Education and Welfare has advised the Department of Health of the inefficiencies of the separation of these functions and has recommended consolidation of the MSR and licensing activities.

Since MSR teams review facilities at other times of the year than does the licensing unit, there exists the potential advantage of a more continuous review of facilities by having the MSR teams investigate facility compliance at different times during the course of the year and report their findings to the licensing unit. However, in the absence of better communication between the two units, this potential, with few exceptions, has remained unrealized.

Medical review activity is mandated by federal regulations and failure to review patient placement could jeopardize federal funding. We are, therefore, not recommending that the function be discontinued.

In our judgment, therefore, the Department of Health should, as a minimum, implement the HEW recommendation to consolidate these two functions into a single system in order to increase their efficiency and effectiveness.

Comments From County Health Directors Regarding the Effects of Reorganization on Health Services.

One county health officer wrote that the increased waiting period was "frustrating" and sometimes resulted in "delayed implementation of programs or provision of service". He blamed the increase in the time required to get information from the department on: "Lack of coordination among the several systems, (and) difficulty in identifying personnel who were authorized to or capable of taking the action needed." Another county director of health programs indicated that it takes longer to get a decision or information out of the State Department of Health than it does other state agencies. He wrote, "This prevents us from

responding to our public's service request within a reasonable amount of time." Another county health director said the most single noticeable effect of consolidation has been that "mid-management personnel have no confidence that their decisions will be upheld through the myriad of hierarchy".

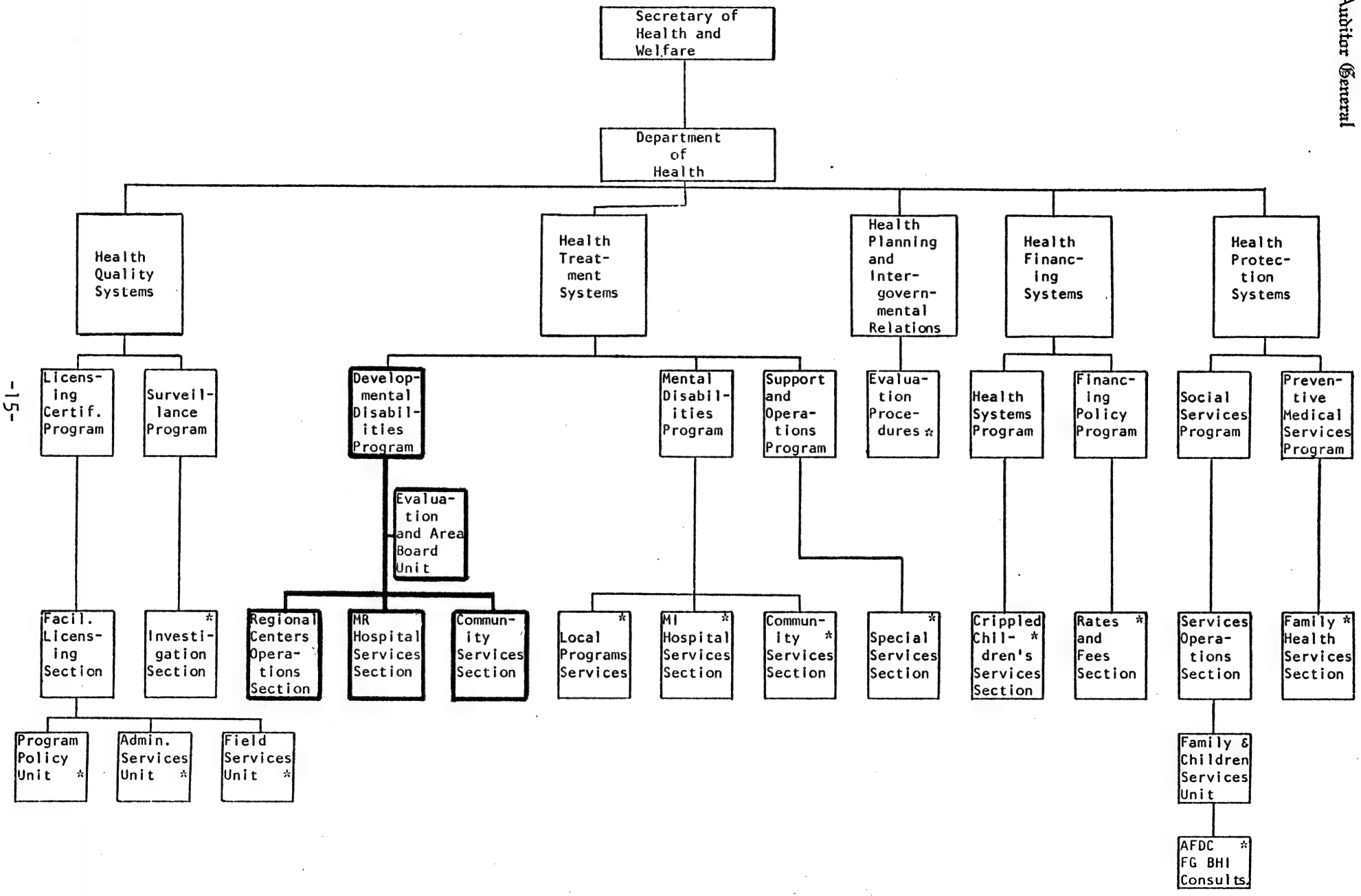
III. Other Health Services

a) Developmentally Disabled

The organizational structure of the programs designed to provide services for the developmentally disabled is reproduced on the following page (bold outline). The chart also identifies 13 other operating program units, identified with an asterisk, within five "systems" within the Department of Health that the developmentally disabled program must coordinate activity with, if services for the mentally retarded are to be effectively and efficiently delivered. Those units that provide only administrative and fiscal services have not been included.

This chart is not intended to demonstrate the fragmentation of the developmentally disabled program which with its 13 regional centers is better equipped to provide direct services than other Department of Health programs. It is intended to show the fragmented environment in which this program functions. However, one result of such program fragmentation is that there is no means to measure program effectiveness since none of these units within the Department of Health involved in the provision of services to the developmentally disabled presently accumulate adequate statistical information.

ORGANIZATIONAL STRUCTURE OF THE DEVELOPMENTALLY DISABLED PROGRAM AND COORDINATED FUNCTIONS



This kind of organizational structure creates duplication and waste in manpower and time by requiring multiple local and state agency contacts with these units in order to obtain information and guidance.

b) Community Mental Health Services

Support services to the developmentally disabled represent only one aspect of program fragmentation in the area of mental health services. The director of the Department of Health is required to consult with the California Conference of Local Mental Health Directors (CCLMHD) in establishing standards, rules and regulations under provisions of the Community Health Services Act.

In February 1975, we released the results of our management review of the California Community Mental Health System. Included in that report, was an analysis of the State Department of Health reactions to 24 recommendations which were made to the State Department of Health in the form of resolutions by CCLMHD.

In that management review, we reported:

> "In order to determine the effectiveness of communication between the Department of Health and the Conference, we examined 24 conference recommendations made to the director between July 1972 and June 1974. In most cases, responses by the Department of Health were able to be documented, but only after extensive investigation which led well beyond the Office of the Executive Secretary of the Conference. Some responses were able to be documented by the Executive Secretary of the Conference, but other responses were traced to eight other units within the Department of Health; these other units were: the Local Programs Services Section, Mentally Ill Hospital Services Section, the Substance Abuse Program, the Office of Evaluation Procedures, the Budget Section, Fiscal Analysis and Accounting Systems Section, Patient Benefits and Accounts Section, and the Manpower Development and Training Section."

c) Fragmentation of Programs Between the Department of Health and the Health and Welfare Agency

The following three program units located in the Health and Welfare Agency duplicate to a significant degree, program efforts of counterpart units within the Department of Health:

- The Office of Alcohol Program Management (OAPM)
- The State Office of Narcotics and Drug Abuse (SONDA)
- The Office of Developmental Disabilities.

The Legislative Analyst has recommended that these offices be abolished and their functions and personnel be transferred to the Department of Health.

Comments From County Mental Health Directors Regarding the Effects of Reorganization on Mental Health Services

Perhaps the single most noticeable facet of county mental health program directors' responses to our questionnaire was the fact that nearly half (47 percent) of them said they had been unable to spend already allocated funds due to a failure on the part of the Department of Health (see Question 12 in the Appendix).

Several respondents noted difficulties with financing -- several addressing themselves to the issue of unspent funds. "Allocations are late in coming, e.g., March 9 receipt for beginning January 1. Start-up times are rarely allowed and carryover from the fiscal year to next is not allowed." Another said, "Frequently, we must operate on supposition, and after lengthy staff work, a decision is made which voids all the efforts to date. Program implementations are delayed and money is unexpended."

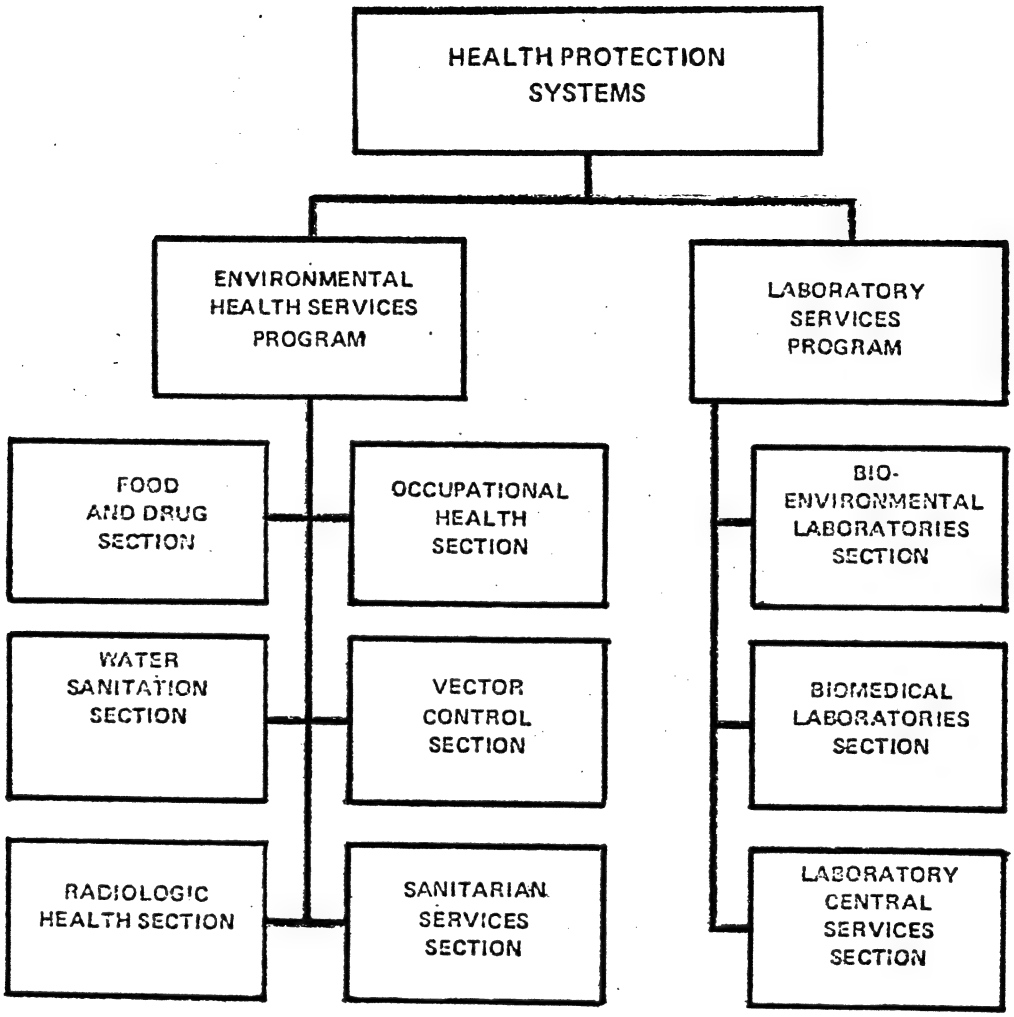
Even when funds are being spent, problems exist. "We are currently having to use Short/Doyle funds when Medi-Cal funds should be used because of the continuing conflicts within the Department of Health", one county director of mental health wrote.

IV. Environmental Health Services

Programs relating to Environmental health, administered by the former Department of Public Health, were least affected by the consolidation aspect of the July 1973 reorganization. (The physical relocation of headquarters staff from Berkeley to Sacramento created a certain amount of confusion which was both anticipated and temporary.)

With the exception of a few programs, the environmental aspects of the Department of Public Health were transferred intact as a unit into the environmental health services program in the new Department of Health's "health protection systems". Those programs not transferred intact along with the rest were crippled children's services, licensing and certification and comprehensive health planning.

With the exception of these three functions and certain internal fiscal and administrative functions not directly affecting the public, the environmental programs of the old Department of Public Health may be found on the following organizational chart.



Responses from county environmental health directors were categorically more favorable toward the new Department of Health than other respondents to the questionnaire. In our judgment, this can be directly attributed to the fact that the programs in the former Department of Public Health which related most directly with county environmental directors were relatively unaffected by the consolidation and reorganization.

On almost every question the directors of environmental health were more satisfied than the group as a whole. They had less trouble finding out who

to talk to (22 percent as opposed to 53 percent overall -- question 3 in the Appendix). Sixty-seven percent described the department as more prompt or at least as prompt as other departments in getting information or a decision as opposed to 61 percent overall (question 5). And the responses once they came were deemed adequate (82 percent to 58 percent overall -- question 11).

Fewer reported that they had to make administrative changes in order to accommodate the consolidation (21 percent as opposed to 33 percent overall -- question 13f) and more saw a change for the better in the last six months (47 percent to 37 percent -- question 14).

V. Effects of Consolidation on County Administrative Cost

Of the 97 responses to our questionnaire from county program directors, sixty-three indicated that their tenure as a director permitted them to make comparisons of the Department of Health's management capabilities, both before and after the July 1973 consolidation. The table on page 21 presents a summary of their views on the effect of consolidation at the state level on local administrative costs. This table was developed from the answers to questions 13h and 13i in the Appendix.

COUNTY PROGRAM DIRECTOR	CONSOLIDATION CAUSED LOCAL ADMINISTRATIVE COSTS TO:		
	Increase	Decrease	Remain 1/ The Same
Alcohol	0.0%	0%	100.0%
Health	16.7%	0%	83.3%
Environmental Health	22.2%	0%	77.8%
Mental Health	18.8%	0%	81.2%
Welfare	21.2%	0%	78.8%
TOTAL	19.0%	0%	81.0%

1/ Includes four directors who did not answer this item.

While the above data does not conclusively demonstrate that county administrative costs have been adversely effected by consolidation of functions at the state level (for example, only one in five county directors stated this to be the case), it is significant that not one county director responding to our questionnaire could cite evidence that consolidation at the state level improved the efficiencies of administration at the county level. To the contrary, the review of Medi-Cal by the Department of Finance discussed on Page 11 indicates that efficiency at the county level has decreased as a result of the consolidation, at least in that program.

CONCLUSION

The current organizational structure of the Department of Health has not accomplished its stated goals and in fact, that structure has adversely effected the department's abilities to meet the needs of the people and institutions it was designed to serve:

- Program integrity and continuity has been further fragmented making the establishment of priorities and the development of accountability more difficult, not less

- While the results of the questionnaire do not demonstrate complete dissatisfaction with the department, and in some instances are actually supportive, the results demonstrate that the relationship between the state and local governments responsible for the delivery of services, has deteriorated since reorganization.

RECOMMENDATIONS

Recognizing that another reorganization of the Department of Health of the magnitude of that taken in July 1973 would in and of itself be disruptive to orderly administration, we are not making such a recommendation. However, as changes in the Department's structure are made in the future, we are recommending that they be made in the direction of consolidating program efforts and not functions.

We further recommend that:

- All reorganization efforts be directed toward pinpointing responsibility and accountability, rather than diffusing these basic requirements of good administration

- The department take immediate steps to relocate medical-social review teams in the licensing unit where these functions can be coordinated

- Responsibility for meeting federal requirements involving the provision of social services be immediately established and that the necessary steps be taken to ensure that the state not be found out of compliance with these requirements.

BENEFITS

Implementation of these recommendations will, over the long run, improve substantially the Department of Health's ability to deliver effective health related services. Immediate benefits include the removal of potential barriers to continued federal participation in the social services program and the more efficient use of medical-social review teams.

ROTATION OF MANAGEMENT STAFF OF THE DEPARTMENT OF HEALTH HAS BEEN EXCESSIVE. AS A RESULT, PROGRAM GOALS LACK CONTINUITY AND INDIVIDUAL RESPONSIBILITY AND ACCOUNTABILITY FOR PROGRAM RESULTS CANNOT BE ACCURATELY ASSESSED.

The State Personnel Board regulations governing managerial class levels provide that incumbents have at least one year of experience in a job classification in order to be deemed proficient at that job level. The one-year period serves as a probationary term during which the incumbent's performance can be appraised to determine if the employee efficiently discharges his duties so as to warrant permanent status.

A clear distinction can be drawn between the personnel rules governing classification permanency and the staff rotations experienced by the Department of Health management staff. The State Personnel Board feels that in order to be able to fairly judge whether an individual's performance has been satisfactory takes at least a year. Yet, management staff of the Department of Health have found it common to be rotated in much shorter time spans, sometimes within a matter of weeks.

At best, these new managers of necessity require an orientation period to adjust to their new responsibilities which creates at least temporarily, a deterioration in both program quality and sub-managerial employee morale. Moreover, members of the public and other interested parties have considerable difficulty in locating persons of responsibility capable of providing direct answers to fundamental questions. At worst, such large-scale rotation results

in the lack of continuity in the mangement of program priorities and the absences of accountability for achieving program results.

The cumulating impact of the staff rotations and lack of program continuity is exemplified when you examine several of the major programs administered by the department:

Developmentally Disabled Program

Management staff that administer this program in the Department of Health have been rotated, on the average, twice since July 1, 1973 (see organization chart of the Developmentally Disabled Program on page 15). Mass rotation of administrators in this program not only serves to disrupt matters at the state level, but also causes confusion and inefficiencies at the local levels.

County administrators responding to our questionnaire frequently cited staff turnover at the Department of Health a primary problem effecting their ability to administer local programs. One county administrator said:

> "...in addition to staff rotation and staff turnover, persons who answer the phone don't always know the new extension of the person we're calling. When we reach the person we're calling, it is not unusual to find he has a new assignment. When we track down his successor, we have to start from scratch again on the subject matter about which we're calling."

Tables 3, 4 and 13 b in the appendix deal with the issue of staff turnover.

Health Services

The management of prepaid health plans (PHPs) has been criticized from a number of sources in the past several months. Our previous reports questioned the department's management of these plans (see Prepaid Health Plan Reports, April 1974 and July 1974). The State Department of Finance's December 1974 audit of the Medi-Cal program pointed out that management of the PHPs has major problems. The Department of Finance asserted that the single most important person in the entire process of supervising and monitoring PHPs is a class of employee called contract manager.

An article in the February 1975 issue of the California Journal entitled "What Went Wrong with Prepaid Health Plans?" contained the following comment:

> "The state Department of Health's awareness of day-to-day operations in the 'field' is extremely limited. The large turnover of leadership and the shuffling of personnel within the department is indicative of an organization in distress. PHPs are required to work closely with the department's 'contract managers', whose chief responsibility is dealing with basic communication and operational problems. Familiarity with the PHP and its personnel is essential to this task, and the department's shuffling of its people from position to position has rendered this difficult if not impossible."

The chart on the following page documents the turnover of contract managers for the 25 PHP contracts which have been in effect since at least June 30, 1973. This turnover occurred between the period July 1, 1972 through October 30, 1974. On the average, each of the 25 PHP contracts had 4.5 different contract managers employed by the Department of Health over the period of two years and four months.

Name of Prepaid Health Contract	Each line segment indicates the period of time selected[1] PHP contracts were assigned to an individual manager	Number of Mgrs Per Health Plan
	1972 (3 6 9 12) 1973 (3 6 9 12) 1974 (3 6 9 12)	
Central Region		
- De Paulo		5
- Omni-Rx		5
- Hawthorne		5
- Los Angeles Health Foundation		4
- Community Care (Marvin)		5
- South Los Angeles Community Health Plan		4
- Medbrook		3
- Gardena		4
- Calif. Nat'l. Westland (Watts Extended)		3
- Americare		4
- Rose		3
- UMEDCO		3
- Harbor		7
- Central Los Angeles Health Plan		4
- CMS		7
- FHP		8
San Diego Region		
- Kaiser		5
- HCS Corporation		4
- CMS, San Diego		3
- CMS, Orange		4
- CMS, San Bernardino		4
Northern Region		
- Alviso Family Health Center		4
- Foundation Community Health Plan		5
- Fresno, Madera Utilization Review		3
- San Joaquin[2]		6

1/ Criteria for selection: Contract must have been in effect before 6/30/73.

2/ Began as pilot project February 1970.

Source: Auditor General's Office Analysis of Data from Operations Section, Health Systems Program.

Management Staff Turnover Has Been Prevalent Throughout the Department of Health.

In order to quantify the degree of management staff turnover throughout the Department of Health, we analyzed the movement of 93 employees who held a position of bureau chief or above in the department on July 1, 1974. The analysis involved a count of the number of different positions these individuals have held between July 1970 and October 1974*.

Of the 93 administrators shown on the department's organization chart, 43 or 46.2 percent have changed jobs five times or more since July 1970. Although almost all of the movements took place within the Department of Health and its predecessor agencies, this count includes a small number of changes between other state departments. Within Health, it includes inter-health system and unit movement, and promotions. The analysis does not include the PHP contract managers discussed on Pages 26 to 27. Further, it does not include intra-unit changes at Health even though responsibilities may have changed substantially because the department does not maintain that kind of data. Nor does it include promotions which did not result in a change in responsibilities. Nor does it include transfers out of the department after July 1, 1974. Finally, our analysis did not include changes in titles that did not result in a change in duties. The movement of these 43 employees breaks down as follows:

*We recognize that the Department of Health has only been in existence since July 1, 1973. We are making reference here to those management employees in the Department of Health on July 1, 1974 and rotation of those employees prior to July 1, 1973 in the departments and programs which subsequently became part of the Department of Health, as well as rotations after the Department of Health became an operating agency on July 1, 1973.

Staff Members	Time Changed Positions	Average Number of Months Position Held July 1970-Oct. 1974
33	5.0	10.2
6	7.0	7.3
2	8.0	4.8
1	10.0	5.2
1	11.0	4.7
43	5.7	8.9

This detail takes on added significance when viewed in the context of Personnel Board recommendations that incumbents acquire at least one year of experience in a job classfication in order to be deemed proficient at that job level.

To further complicate the problem, the department has been in a continual state of reorganization since July 1973. Several reorganizations have taken place without the knowledge of the department's budget section. The latest such reorganization, which we found was a major one that took place July 1, 1974, in which 30 percent of the 90 program administrators shown on the February 1, 1974 organizational chart at the section chief and above level were rotated. The July 1, 1974 chart reflected 93 such administrative positions. Section 3000 of the Health Administrative Manual (HAM) outlines a procedure whereby sections affected by reorganization can be notified in advance of impending changes. This HAM provision has not been consistently followed. As a result, program continuity and program integrity have been severely impaired.

Staff Turnover Has Resulted in an Excessive Number of Employees with Fiscal or Personnel Backgrounds Assuming Management Positions Previously Held by Employees with Program Specialty Backgrounds.

In addition to analyzing staff turnover among the 93 employees holding positions of bureau chief and above on July 1, 1974, we compared their educational and employment histories with the civil service specifications for the positions which they held.

There were 31 positions in the administrative and financing systems units requiring a fiscal and/or general administrative background. These positions were all filled by employees whose resumes generally reflected this kind of experience with the exception of three employees whose primary experience was in the personnel field.

Another eight positions were either exempt from civil service requirements or called for general administrative experience.

Fifty-four positions in the Department of Health require the incumbent to have a more specialized background either in terms of education or work history or both. The incumbents in 40 of these 54 positions had resumes that to some degree reflected the appropriate qualifications for the positions held. However, 14 of the 54, or 26 percent, of the total positions in the Department of Health requiring a specialized program oriented background were filled by employees whose education, training and previous work experience had been limited to fiscal expertise

In our judgment, the use of staff who lack appropriate professional background at the very least hinders the ability of the staff they supervise to

effectively implement the programs that they have worked with for years, since they are supervised by people who often are unable to recognize the complexities of these programs.

Comments of County Directors Regarding
The Effects on Program Management

Concern over the declining level of staff expertise in the Department of Health was expressed by several respondents to our questionnaire. One, a county alcohol program director, said the rotation of staff had resulted in a "loss of outstanding people, and demoralization of the remaining (staff)" and "lessened the caliber of the department".

Another respondent clearly blamed the influx of new staff members "without strong backgrounds in or knowledge of the department's services" for the decline of the staff's caliber. "Professionals in social services," he wrote, "have been largely eliminated. Broad 'management' experts do not substitute for content."

A mental health director wrote "the Department of Health has lost most of its clinical program expertise" and a county welfare director said his department was forced to spend more time doing its job because of state health personnel "who lack responsibility, authority and knowledge". "It seems clear," he continued, "that services personnel on the state level do not understand social services as conducted on the county level."

CONCLUSION

The rotation of management staff, both in the Department of Health and in the departments and programs which became part of the department on July 1, 1973 has been excessive. Such excessive rotation makes program continuity unlikely and assessment of individual responsibility and accountability difficult.

RECOMMENDATION

We recommend that the Department of Health take notice of the effects of its excessive staff rotation practices, specifically diffusion of responsibility at the state level and confusion at the county level and adjust its personnel practices accordingly by reducing the rate of staff rotations.

BENEFITS

Implementation of this recommendation will provide program continuity and enable the Department of Health to fix managerial responsibility for program results.

ANY REDUCTION OF POSITIONS MATERIALIZING AS A RESULT OF THE CREATION OF THE DEPARTMENT OF HEALTH CANNOT BE VERIFIED.

A major concept advanced in support of the proposed Department of Health was that 600 positions could be eliminated through consolidation of related departments. In a letter to the Senate Finance Committee, dated March 12, 1973, the Director of Health stated:

> "...with the additional organizational review and modification, it became apparent that significant reductions could be made as a result of this consolidation. This reduction was taken from a base that reflected increases in the three departments to meet specific expansions. These substantial increases were throughout the departments and were necessary to accomplish the separate goals of the departments prior to consolidation. Key members of the departmental staff agreed a goal of close to six hundred positions was reasonable because of the consolidation and the program review..." (Emphasis added)

This could be accomplished according to health department officials because under the organizational structures of three related old departments, there was a great deal of fragmentation which not only resulted in duplication of services and increased administrative costs, but also hindered the delivery of comprehensive care for the individuals needing services.

In reality, it is virtually impossible to verify that even one position has been saved as a result of the reorganization.

The projected 1973-74 year-end position figure of 20,950.1 would make it appear that 443.5 positions had been saved since the department started the 1973-74 year with 21,393.6 positions. The department reported it was eliminating 600 positions within the five systems that make up the department. The Legislature restored 98.6 of these positions and the department itself restored 496.2 positions. Thus, 594.8 positions were restored.

The dynamics that were primarily responsible for the appearance of a drop in staffing of 443.5 are as follows. The neuropsychiatric institutes and their 1,025.7 employees were transferred to the University of California. The Healing Arts Boards and their 224.4 employees were transferred to the Department of Consumer Affairs. In addition, 904 employees were transferred into the department from other agencies, primarily Social Welfare and Rehabilitation. The net effect of these transfers was to reduce the number of employees assigned to the Department of Health by 346.1. Finally, the Department of Health was able to eliminate (99.9) positions because of revisions to the Treatment Authorization Request (TAR) process, which did constitute an actual reduction in positions but was unrelated to reorganization. This item and the net effect of transfers resulted in a reduction in the department's payroll of 446. Other activities that affected position counts included decreasing caseloads in state hospitals, resulting in a total net reduction of 443.5.

We were informed by a former director of the Department of Health that:

> "Regarding the alleged 600 position saving, this was a fiat by (the agency secretary) which, despite my appeals, was not open to discussion. The staff work on the 600 positions had to be done after the number 600 was arrived at, not before."

No detailed position study or evaluation was ever performed and no statistical data exists to substantiate this proposed reduction of staff.

Context of the 600 Staff Reduction Estimate

Department of Health staff was informed that there would be a 1,000 position reduction on orders of the Health and Welfare Secretary. Department officials compromised with the secretary's representatives at the 600 position figure. The department's budget was then constructed to reflect this reduction in staff. However, the original 1973-74 budget submitted to the Legislature was rejected because the proposed Department of Health position figures could not be reconciled with the old department's position figures, nor did it show exactly where the position cuts were to be made.

Second 1973-74 Budget Prepared

Department of Health officials then prepared another budget for submittal which was to delineate the positions by bureau and to answer all the questions of the Legislature. Specific instructions to the systems chiefs were that their prepared budget should emphasize:

> "...(1) economies of scale related to consolidation; (2) anticipated efficiencies owing to reorganization; (3) program redirection. Where acceptable workload standards are available and in use or contemplated, those standards should be enumerated...the Department position is that present programs within the various departments will be continued without a decrease in quality or level of service..."

The budget was later accepted by the Legislature as the department's official budget. However, DOH officials knew then that the department could not reconcile its positions due to the hastiness of the merger and poor personnel recordkeeping of certain old departments. Department staff is still trying more than one year later to reconcile their records to the point where they can make a precise determination of what positions are, where and the exact number of people working for the department.

We made several unsuccessful attempts to determine what positions were transferred to the new organization. DOH officials agreed with us that such an assessment almost defied analysis. They also informed us that they are attempting to reconcile by taking a section-by-section count of the number and titles of persons actually working and comparing it to the actual number of positions authorized by the Legislature.

CONCLUSION

Any reduction in the aggregate staff of the departments making up the Department of Health resulting from the creation of that department cannot be verified.

SUMMARY OF COMMENTS OF THE ACTING DIRECTOR OF THE DEPARTMENT OF HEALTH AND HIS STAFF

The Acting Director and his staff reviewed this report and expressed both appreciation for the information it contains and general concurrence with the findings and recommendations. Specific comments were withheld pending a more detailed analysis.

Number of Questionnaires Mailed to Program Directors in 20 Largest Counties and Number Returned by Program Category

Response	Total	Program Category				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
Mailed	120	26 1/	20	20	34 1/	20
Returned	97	20	16	18	22	21 2/

1/ Exceeds 20 because the organizational structure of 6 county alcohol and 14 mental health programs required two questionnaires

2/ Exceeds 20 because 2 county welfare departments returned 2 schedules and 1 county did not respond.

NOTE: Three questions, Numbers 1, 2 and 6 asked for general comments and are not included in this Appendix.

Question No. 3

In your current dealings with the Department of Health, have you found any difficulty in identifying the office or individual with whom you must deal?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	53.3	40.0	62.5	22.2	60.0	76.2
No	46.7	60.0	37.5	77.8	40.0	23.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	90	15	16	18	20	21

Note: County Directors of Health, Mental Health and Welfare responsible for the administration of 59 county programs returned completed questionnaires. Thirty eight of them, or 64 percent, expressed difficulty in identifying either the office or the individual in the Department of Health with specific program responsibility. In our judgment, this is due to both a fragmented organizational structure and the rapid turnover of staff; however, staff turnover in the Alcohol and Environmental Health Programs has been almost as great but organizational fragmentation has been less significant. Greater dissatisfaction with the State Department of Health's ability to provide service and leadership among County Directors of Health, Mental Health and Welfare is evident throughout the balance of the questionnaire.

Question No. 4

In your current dealings with the Department of Health, have you found any sustained difficulties in reaching those people with whom you must deal on a regular basis?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	35.3	28.6	46.7	22.2	31.6	47.4
No	64.7	71.4	53.3	77.8	68.4	52.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	85	14	15	18	19	19

Note: This question was more directly related to staff turnover. The similarity of responses among all categories of program directors supports the thesis that program fragmentation is greater in the Health, Mental Health and Welfare Programs than in the Alcohol and Environmental Health Programs.

Question No. 5

Please mark the box which best describes the length of time you must spend getting a decision, advice or other information from the Department of Health.

Response 1/	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Shorter than with other departments	48.9	56.2	56.2	61.1	42.9	31.6
Equal to other state departments	12.2	12.5	25.0	5.6	4.8	15.8
Subtotal	61.1	68.7	81.2	66.7	47.7	47.4
Longer than with other departments	38.9	31.3	18.8	33.3	52.3	52.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	90	16	16	18	21	19

1/ The actual questionnaire gave the respondent the opportunity for additional responses; for example, the respondent was also provided answers such as usually prompt and usually excessive to describe the department's reaction time. These answers have been combined in this table respectively with the categories "Shorter than" and Longer than with other departments" for ease of presentation of the data.

Note: More than half of the County Mental Health and Welfare Directors found the Department of Health less responsive than other state agencies such as Benefit Payments, Vocational Rehabilitation and Employment Development.

Question No. 7.a.

When you have a request for information, policy explanation, clarification of regulations or advice, is the quality of the response adequate?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Response adequate	62.7	66.7	78.6	70.6	53.0	50.0
Response inadequate	37.3	33.3	21.4	29.4	47.0	50.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	83	15	14	17	17	20

Note: Again the greatest degree of dissatisfaction with the Department of Health was expressed by County Mental Health and Welfare Directors.

Question No. 8.a.

If you have found occasion to criticize, make suggestions or otherwise make your needs known to the department, how have you been received?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Usually well	52.3	64.7	53.3	61.1	23.5	57.2
Occasionally well or Occasionally put off 1/	30.7	5.9	40.0	22.2	70.6	19.0
Usually put off	8.0	11.8	-0-	5.6	5.9	14.3
Not applicable	9.0	17.6	6.7	11.1	-0-	9.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	88	17	15	18	17	21

1/ This item consisted of two separate responses in the questionnaire and because of the overlapping nature of the item resulted in duplicate responses. To eliminate that duplication, the categories have been combined in this table.

Note: The incidence of strong dissatisfaction expressed with the Department of Health's channels of communication is fairly low. However, it should be noted that fewer than one in four County Mental Health Directors expressed a high degree of acceptance of the department's methods of communication. This is consistent with the Auditor General's finding in February 1975 that "Communication between the Department of Health and County Mental Health Programs is inadequate for the effective joint management of the Community Mental System".

Question No. 9

Have you found a willingness on the department's part to seek out your suggestions, comments and advice before the publication of new policies or regulations?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	46.5	35.7	30.8	61.1	42.1	55.0
No	45.2	50.0	46.2	38.9	52.6	40.0
Not Applicable	8.3	14.3	23.0	-0-	5.3	5.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	84	14	13	18	19	20

Question No. 10

Are you satisfied with the number of visits the program(s) you are interested in receives from the Department of Health personnel?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	56.6	58.3	57.1	52.9	73.7	57.1
No	43.4	41.7	42.9	47.1	26.3	42.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	83	12	14	17	19	21

Note: The high incidence of satisfaction among County Mental Health Directors with the number of visits from state staff apparently results from the presence in each county of a community program analyst employed by the State Department of Health to serve as liaison between the state and county agencies.

Question No. 11

Are you satisfied with the quality of advice and technical assistance you receive from Department of Health personnel when they visit your local program(s)?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	58.3	57.2	60.0	82.3	52.9	43.0
No	26.2	7.1	26.7	11.8	41.2	38.0
Not Applicable	15.5	35.7	13.3	5.9	5.9	19.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	84	14	15	17	17	21

Note: The lower incidence of satisfaction expressed by County Mental Health Directors with the quality of advice and technical assistance received from state staff is consistent with the Auditor General's finding in February 1975 that "The Community Program Analysts on the staff of the local program services section lack the strong combination of program and fiscal experience that is required to perform their duties effectively". It should also be noted that fewer than half of the County Welfare Directors expressed satisfaction with the quality of technical assistance received from the State Department of Health.

Question No. 12

Have you been unable to spend allocated money on your program(s) because of any failure on the department's part to issue regulations, policies, standards, licenses, etc.?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	29.8	33.3	30.8	22.2	47.4	15.8
No	70.2	66.7	69.2	77.8	52.6	84.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	84	15	13	18	19	19

Question No. 13.a.

Does your knowledge of the Department of Health's operations permit you to compare its current effectiveness with the effectiveness of the departments that were consolidated into the Department of Health in July 1973?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Number	Number	Number	Number	Number	Number
Yes	63 1/	7	12	14	16	14
No or No Response	34	13	4	4	6	7
Total	97	20	16	18	22	21

1/ Items 13.b. through 13.i. are based only on the answers of those respondants who answered yes to this question.

Note: The six tables following provide a comparative analysis of the Department of Health's management capabilities before and after the July 1973 consolidation. Only the answers of those county directors whose tenure in their assignment permitted this kind of comparison were tallied.

Question No. 13.b.

How has the number of offices and people you must currently deal with in the Department of Health changed since the 1973 consolidation?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
More	56.0	42.9	60.0	23.0	66.7	78.6
No change or not applicable	33.9	57.1	30.0	69.3	13.3	14.3
Fewer	10.1	-0-	10.0	7.7	20.0	7.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	59	7	10	13	15	14

Note: The comments to Table 3 regarding both program fragmentation and staff turnover are again reflected here.

Question No. 13.c.

Has the length of time involved in getting a decision, advice or information changed since the consolidation?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Decreased	11.1	14.3	8.3	-0-	25.0	7.2
Increased	52.4	42.8	58.4	35.7	50.0	71.4
About the same	28.6	28.6	8.3	64.3	18.75	21.4
Not sure	7.9	14.3	25.0	-0-	6.25	-0-
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	63	7	12	14	16	14

Question No. 13.f.

Have you had to make changes in your office or program to accommodate this increase?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	33.3	28.6	50.0	21.4	25.0	42.9
No	66.7	71.4	50.0	78.6	75.0	57.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	63	7	12	14	16	14

Question No. 13.h.

Have you had any increases in administrative overhead costs that are directly attributable to the consolidation?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	22.2	-0-	25.0	28.6	18.75	27.2
No	77.8	100.0	75.0	71.4	81.25	72.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	54	5	8	14	16	11

Question No. 13.i.

Have you had any decrease in administrative overhead costs that are directly attributable to the consolidation?

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	-0-	-0-	-0-	-0-	-0-	-0-
No	100.0	100.0	100.0	100.0	100.0	100.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	56	6	7	14	15	14

Note: This is the only question in the survey that produced consensus in all five program categories.

Question No. 14

Has there been any noticeable improvement in the department's operations in the last six months? (April 1974-September 1974)

Response	Total	Program Directors				
		Alcohol	Health	Environmental Health	Mental Health	Welfare
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	37.2	55.6	23.0	47.0	36.8	30.0
No	62.8	44.4	77.0	53.0	63.2	70.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number Responding	78	9	13	17	19	20

Note: This question was included at the specific request of the Department of Health.